STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105250	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Point Health and Rehabilitation Center	1775 Huntington Lane Rockledge, FL 32955

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to protect the residents' right to be free from abuse and neglect by not ensuring staff utilized a mechanical lift for transfer of resident #1 resulting in a leg fracture, for 1 of 9 residents reviewed for transfers with a mechanical lift, out of a total sample of 10 residents, (#1).On 10/16/25 at approximately 2:40 PM, the facility failed to ensure nursing staff followed resident #1's plan of care for safe transfers resulting in serious injury and pain of the physically impaired resident during a transfer from wheelchair to bed. Two certified nursing assistants (CNAs) failed to follow resident #1's care plan which required her to be transferred using a mechanical lift with assistance of two staff. The two CNAs transferred the resident from her wheelchair by manually lifting the resident and pivoting her to the bed. Resident #1 complained of pain in her left leg during the transfer and was lowered to the floor. The two CNAs then manually lifted her from the floor and placed her in bed. Resident #1 continued to complain of extreme pain to her left leg. An X-ray performed on 10/17/25 of resident #1's left leg indicated she had sustained a fractured tibia. Record review revealed a total of 23 residents were identified in the facility who required a mechanical lift for transfers. The facility's failure to ensure staff transferred residents according to their transfer status and care plan contributed to the injury of resident #1 and placed her and all other residents who required mechanical lifts for transfer at risk for serious impairment and/or death.This failure resulted in Immediate Jeopardy which started on 10/16/25 and was removed on 10/21/25 after verification of the immediate actions implemented by the facility. The scope and severity was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.Findings: Cross reference F689 Review of the medical record revealed resident #1, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included hemiplegia and hemiparesis (one-sided weakness and paralysis) following stroke affecting left non-dominant side, obesity, chronic lower back pain and muscle weakness. Review of resident #1's Quarterly Minimum Data Set assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status score of 15/15 which indicated she was cognitively intact. The assessment indicated resident #1 was dependent on staff for transfers. It was noted that due to her medical conditions and/or safety concerns, evaluations of resident's ability to sit to stand, transfer to the toilet or walk ten feet were not attempted. Review of the resident's electronic medical record (EMR) revealed an Activities of Daily Living (ADL) self-care performance deficit care plan initiated 5/30/23 and revised 10/18/25. The care plan contained an intervention which identified resident #1 as dependent (on staff) for transfers and required the assistance of 2 staff using a total mechanical lift. Review of the ADL task history revealed resident #1 was first identified as requiring the use of a mechanical lift on 5/16/24. In a phone interview on 10/27/25 at 12:08 PM, CNA A confirmed she was resident #1's assigned CNA on 10/16/25. She recalled resident #1 put on her call light and asked to go back to bed around the end of the shift. CNA A stated she was not aware of resident's transfer status or where to find the information but resident #1 told her that staff usually got her up with a 2-person pivot. CNA A explained she looked outside the room and asked another staff member to help her. CNA A stated she did not know the name of the other CNA she asked for assistance. She recalled that resident #1 said she had a little pain during the transfer and they lowered her to the floor, gave her a few minutes to rest and then lifted her and transferred her to bed. CNA A acknowledged she did not report the complaint of pain to the nurse. She explained it was the end of the shift and she had already given report and was about to leave when resident #1 asked for help. A witness statement from CNA B given on 10/17/25 revealed she clocked in for work at approximately 2:36 PM on 10/16/25 and went to her assigned unit. She reported that while she was on her way, CNA A opened the room door, saw her and asked her how strong she was. CNA A indicated she needed help with resident #1. CNA B recalled she recognized resident #1 but was not aware she required a mechanical lift for transfer. She documented that CNA A told her she would normally use the mechanical lift for resident #1's transfer but would just have the resident stand and pivot to put her in bed. CNA B noted she was hesitant as she observed a mechanical lift sling already under resident #1 in the wheelchair but agreed to help. Her statement indicated the wheelchair was positioned next to the bed with the left side of the wheelchair turned slightly toward the bed with the wheels locked. The statement indicated CNA B and CNA A stood on either side of resident and lifted her under her arms. CNA B reported the resident felt like dead weight. The statement indicated resident #1 started yelling about her leg hurting during the transfer. CNA B looked down and saw resident #1's left foot was turned in slightly. She reported

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a safe environment to prevent an accident resulting in leg fracture during resident transfer, for 1 of 9 residents reviewed for use of mechanical lifts, of a total sample of 10 residents, (#1).On 10/16/25 at approximately 2:40 PM, the facility failed to ensure nursing staff followed resident #1's plan of care for safe transfers resulting in serious injury and avoidable pain of a physically impaired resident during a transfer from wheelchair to bed. Two certified nursing assistants (CNAs) failed to follow resident #1's care plan which required her to be transferred using a mechanical lift with assistance of two staff. The two CNAs transferred the resident from her wheelchair by manually lifting her to an upright position and pivoting her to the bed. Resident #1 immediately complained of pain in her left leg during the transfer and was lowered to the floor. The two CNAs then manually lifted her from the floor and placed her in bed. Resident #1 continued to complain of extreme pain to her left leg. An X-ray performed on 10/17/25 of resident #1's left leg indicated she had sustained a fractured tibia (lower leg). Record review revealed a total of 23 residents were identified who required a mechanical lift for transfers. The facility's failure to ensure staff transferred residents according to their transfer status and care plan contributed to the injury of resident #1 and placed her and all other residents who required mechanical lifts for transfer at risk for serious impairment and/or death.This failure resulted in Immediate Jeopardy which started on 10/16/25 and was removed on 10/21/25 after verification of the immediate actions implemented by the facility. The scope and severity was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.Findings: Cross reference F600 Resident #1, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included hemiplegia and hemiparesis (one-sided paralysis and weakness) following stroke affecting left non-dominant side, obesity, chronic back pain and muscle weakness. Review of resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated she was cognitively intact. The assessment indicated resident #1 was dependent on staff for transfers. It was noted that due to her medical conditions and/or safety concerns, evaluations of resident's ability to sit to stand, transfer to the toilet or walk ten feet were not attempted. Review of the Significant Change MDS assessment dated [DATE], after resident #1 sustained the tibia fracture, revealed a decline in mood from the previous assessment. Resident reported feeling down, depressed or hopeless and had a poor appetite for 7 to 11 of the previous 14 days; and reported trouble falling or staying asleep or sleeping too much and feeling tired or having little energy for 12 to 14 of the previous 14 days. The assessment also showed a decline in resident #1's functional status and documented she became dependent on staff for sit to lying, lying to sitting on side of bed. Resident #1 reported an increase in pain frequency which occasionally made it hard for her to sleep at night. Her worst pain over the last five days increased from a pain intensity of 5/10 on the Quarterly assessment to a pain intensity of 7/10 on the Significant Change assessment after the incident. Review of the resident's electronic medical record (EMR) revealed an Activities of Daily Living (ADL) self-care performance deficit care plan initiated 5/30/23 and revised 10/18/25. The care plan indicated resident #1 had a recent fracture of left tibia. The interventions identified resident #1 as dependent for transfers and required the assistance of two staff using a total mechanical lift. The ADL task history showed resident #1 was first identified as requiring the use of a mechanical lift on 5/16/24. Review of physician orders revealed an order dated 10/17/25 for non-weight bearing pending orthopedic appointment and to apply brace to left knee for immobilization. An order dated 10/21/25 read, Transfer to ER [Emergency Room] for evaluation of left tibia fx [fracture]. The EMR contained a radiology results report from 10/17/25 which revealed resident #1 sustained a left proximal (closer to the body) tibia fracture with mild displacement. Review of resident #1's Medication Administration Record (MAR) for October 2025 revealed between 10/01/25 to 10/16/25 resident #1 had complaints of pain on 6 days. Her complaints of pain increased to daily, after the incident from 10/17/25 through 10/28/25. In a phone interview on 10/27/25 at 12:08 PM, CNA A confirmed she was resident #1's assigned CNA on 10/16/25. She recalled resident #1 put on her call light and asked to go back to bed around the end of the shift. CNA A stated she was not aware of the resident's transfer status or where to find the information but resident #1 told her that staff usually got her up with a two-person pivot. CNA A explained she looked outside the room and asked another staff member to help her. CNA A stated she did not know the name of the other CNA she asked for assistance. She recalled that resident #1 said she had a little pain